United States General Accounting Office

GAO

Report to Congressional Requesters

July 1993

NONPROFIT HOSPITALS

For-Profit Ventures Pose Access and Capacity Problems

GAO/HRD-93-124

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-248436

July 22, 1993

The Honorable Fortney (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable J.J. Pickle
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The nation's private nonprofit hospitals have long been providers of substantial amounts of medical care for the poor. During the 1980s, to develop new services, raise needed capital, and sustain a base of inpatient referrals from physicians, nonprofit hospitals began increasingly to develop profit-seeking, joint venture arrangements with physicians. These joint ventures provide such services as outpatient surgery and diagnostic imaging. Concerns have developed, however, that the for-profit orientation of joint ventures can contribute to excess capacity in the community for certain medical services without improving access to care for poor patients. Further, out of concern that such ventures could lead to kickbacks or other improper schemes for financial gain, federal and state regulators recently have taken several steps to regulate joint ventures more closely.

This letter responds to your request for information about joint ventures between nonprofit hospitals and physicians. Specifically, you asked us to determine (1) the rate at which nonprofit hospitals participate in joint ventures; (2) the extent to which these ventures, compared to their parent hospitals, serve the poor; (3) the extent that joint ventures can contribute to excess capacity for medical services in their communities; and (4) the effect of recent federal and state regulatory actions on such joint ventures.

Background

Private nonprofit hospitals[1] constitute just over one-half of all U.S. hospitals—about 3,200 in 1992. Their nonprofit status is the basis for such financial benefits as exemption from federal income tax, property tax, and other local taxes; access to tax-exempt bond financing; and tax-deductible status for gifts and contributions. For a hospital to qualify for tax-exempt status under section 501(c)(3) of the Internal Revenue Code, it must be organized and operated exclusively for charitable purposes. For hospitals,

[1]For this report, we refer to them as "nonprofit hospitals."

the Internal Revenue Service (IRS) has defined "charitable purposes" as providing a benefit to the community. Nonprofit hospitals need not provide a specified minimum amount of charity care to qualify for exempt status. However, IRS considers various factors, such as whether the hospital provides medical care to Medicaid and charity patients, in determining whether a hospital provides a benefit to the community.[2]

IRS regulations do not prohibit nonprofit hospitals from participating in for-profit activities, including joint ventures with physicians. Rather, IRS takes a broader perspective and determines whether the hospital, in its entirety, serves a charitable purpose. Joint ventures are often organized as limited partnerships, with the hospitals acting as a general partner. Benefits to the hospital can include developing new services, generating needed capital, and creating or keeping a close relationship between physician and hospital—an important bond for the hospital, because physicians are the main source of inpatient admissions and outpatient referrals to the hospital.

Scope and Methodology

We analyzed data from the American Hospital Association's (AHA) 1984, 1989, and 1991 hospital surveys to determine the nationwide distribution, trends, and types of joint ventures. However, because of privacy concerns, AHA did not provide us the names of individual hospitals with joint ventures. Therefore, to identify nonprofit hospitals that participated in joint ventures, we contacted 95 hospitals and 62 other providers in 5 states in which AHA data showed concentrations of joint ventures—California, Florida, Illinois, Pennsylvania, and Texas. We then judgmentally selected 16 hospitals with joint ventures to develop more detailed financial and utilization information for their operations in fiscal year 1991. These 16 hospitals, which had a total of 23 joint ventures in 1991, were located in three metropolitan areas that AHA data showed have high numbers of ventures—Chicago, Los Angeles, and Philadelphia.

We obtained similar information from the Florida Health Care Cost Containment Board, which conducted its own study of physician ownership of Florida health care facilities in 1991. To obtain information on the status and effect of federal regulatory actions, we interviewed officials from IRS, the Department of Justice, the Department of Health and Human Services' (HHS) Office of Inspector General (IG), and the Health Care Financing Administration. We also interviewed American Hospital

[2]Medicaid is a federally aided, state-administered program that finances health care for the nation's poor. Medicaid reimbursement rates are generally lower than those of other insurers. Uncompensated care must be subsidized by the provider and generally consists of bad debts and charity care.

Association and American Medical Association officials, state health care regulators, health care attorneys, and health policy researchers.

As agreed with your staffs, we limited our detailed analysis of financial and utilization data to ventures that offered specific types of medical care, such as diagnostic imaging centers, ambulatory surgical centers, and clinical laboratories. You indicated greater interest in these types of ventures because of their potential for referrals by physicians who might benefit financially from services the venture provides.[3]

We did not verify the computerized data provided by AHA, nor did we independently review the accuracy of the financial and utilization data reported by hospitals and joint ventures. Other than these exceptions, we did our work in accordance with generally accepted government auditing standards.

Results in Brief

In 1991, about 18 percent of nonprofit hospitals were participating in joint ventures with physicians, according to AHA data. The number of nonprofit hospitals with joint ventures more than doubled between 1984 and 1989 but has decreased slightly since 1989. The percentage of nonprofit hospitals with joint ventures is about the same as the percentage of for-profit hospitals with such ventures.

The 23 joint ventures we reviewed in-depth provided significantly less care to Medicaid and charity patients than their parent hospitals provided. In fact, 13 of the 23 served no Medicaid patients and 6 reported providing no uncompensated care. By contrast, all of their parent hospitals served Medicaid patients and all reported providing uncompensated care.

The 23 joint ventures we reviewed also provided evidence that such projects can contribute to excess capacity for medical services in their communities. For example, one Los Angeles area nonprofit hospital participated in two freestanding outpatient surgery ventures in addition to operating its own resident outpatient surgery department. Because of the excess capacity added by the ventures, the hospital's administrators estimated that one of the freestanding centers could be closed and its workload consolidated into the remaining center and the hospital. The cost of building and maintaining such excess capacity ultimately is added to the cost of providing care in the community.

[3]As also agreed with your staffs, we did not attempt a comprehensive analysis of all potential benefits that might stem from a joint venture arrangement, such as the amount of capital made available for development or whether the venture provided health education in its community.

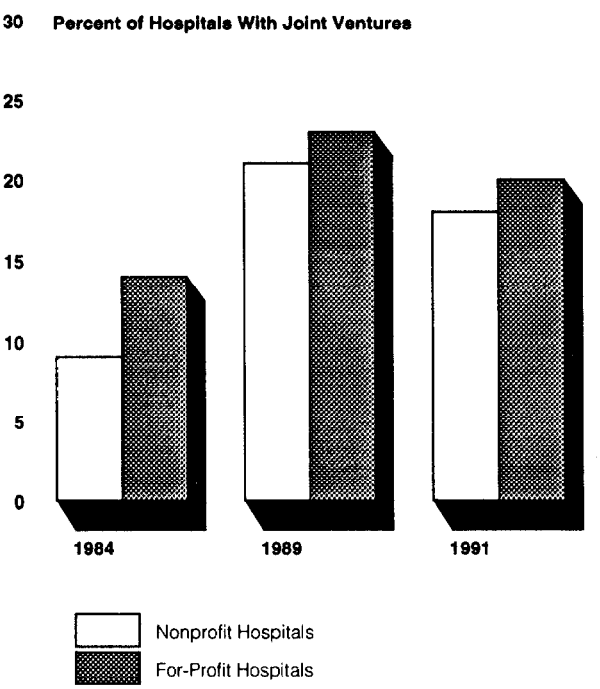
Recent federal legislation, an IRS opinion, and intensified HHS/IG enforcement efforts, while not prohibiting joint ventures between nonprofit hospitals and physicians, contributed to the decline in their numbers. Of the nonprofit hospitals we contacted that participated in joint ventures, about one-third reported having restructured or dissolved joint ventures in response to, and in anticipation of, increasing regulatory pressure. Some states have enacted laws prohibiting physicians from referring patients to facilities in which they have a financial interest. In these states, such laws will, in effect, ban most joint ventures.

Frequency of Ventures Was Similar in Nonprofit and For-Profit Hospitals

AHA data show that the number of nonprofit hospitals participating in joint ventures more than doubled between 1984 and 1989—from 200 to 462. The latter figure was about 21 percent of nonprofit hospitals. By December 1991, participation had fallen to 391 hospitals, or about 18 percent.

Nonprofit hospitals reported participating in joint ventures at nearly the same rate as for-profit hospitals in 1991—18 percent versus 20 percent, respectively (see fig. 1). In 1984, the difference had been greater—9 percent for nonprofit hospitals compared to 14 percent for for-profit hospitals. After 1984, a higher average growth rate of joint ventures among nonprofit hospitals (29 percent) than among for-profit hospitals (21 percent) narrowed the difference. Like ventures at nonprofit hospitals, ventures at for-profit hospitals had decreased slightly by 1991.

Figure 1: Hospital Participation in Joint Ventures



Source: AHA.

The most common types of joint ventures in nonprofit hospitals in 1991 were diagnostic imaging centers (240), outpatient surgery centers (85), and primary care clinics (55). Of the 391 nonprofit hospitals participating in joint ventures in 1991, 110 (28 percent) reported participating in multiple ventures, with up to 7 for an individual hospital. The 391 nonprofit hospitals with joint ventures reported a total of 550 joint ventures—an average of 1.4 ventures per hospital.

Joint ventures involving nonprofit hospitals were concentrated in metropolitan areas. Nonprofit hospitals in such areas made up about 66 percent of the total number of nonprofit hospitals but accounted for nearly 90 percent of joint ventures. Nonprofit hospitals in metropolitan areas were also more likely to participate in multiple joint ventures; 7.4 percent reported participating in two or more joint ventures compared to less than 1 percent for nonmetropolitan hospitals.

Joint Ventures Served Few Poor Patients

The 23 joint ventures we surveyed generally provided substantially less care to poor patients than their parent hospitals provided. The ventures averaged 2.8 percent of their total revenues in care to poor patients (Medicaid revenues and uncompensated care). By contrast, their parent hospitals averaged 11.4 percent. Only two ventures provided as much care to the poor as their parent hospitals did. While all of the hospitals we visited served Medicaid patients and provided uncompensated care, 13 of the ventures we visited reported no Medicaid revenues in 1991, and 6 reported no uncompensated care. The following are examples of such ventures:

- A magnetic resonance imaging (MRI) joint venture in northeast Los Angeles reported no revenue from Medicaid in 1991, while its parent hospital reported 11.3 percent of its total patient revenue from Medicaid. An administrator from the venture told us that the venture did not normally serve Medicaid patients because of low reimbursement rates and late payments from the state. She said that Medicaid outpatients must go to facilities 5 to 10 miles away.[4]
- A diagnostic imaging joint venture in the Chicago area reported providing no uncompensated care in 1991, while its parent hospital, a large teaching hospital, placed the value of its uncompensated care at over $17 million, or about 3 percent of its total revenue.

In some instances, Medicaid and poor patients were able to obtain services at the parent hospital when the joint venture would not serve them. In 9 of the 23 locations we reviewed, the parent hospital also offered the service the joint venture was providing. Although such duplication can mean that poor patients have access to the service, it can also act to the joint venture's financial benefit, because the joint venture is usually serving only those patients with the greatest ability to pay. By contrast, the hospital generally subsidizes the cost of providing the service to poor and Medicaid patients.

Other recent studies have also shown that joint ventures often serve few poor patients. A 1991 Florida Health Care Cost Containment Board study[5] found that Medicaid payments constituted less than one-half of 1 percent of the revenue received by joint venture MRI centers but more than 7 percent of the revenue received by hospitals participating in joint

[4]The joint venture will serve Medicaid recipients who have been admitted to the hospital as inpatients, but the administrator estimated that 92 percent of patients receiving MRI services are outpatients.

[5]Joint Ventures Among Health Care Providers in Florida, State of Florida Health Care Cost Containment Board (Sept. 1991).

ventures. According to the lead researcher, MRI joint ventures involving nonprofit hospitals were no more likely to provide care to the poor and indigent than were ventures involving for-profit hospitals. Another joint venture study, this one involving 17 freestanding MRI centers in Orange County, California, found that none would accept indigent patients and 11 would not accept Medicaid patients.[6]

Joint Ventures Can Contribute to Excess Capacity

The joint ventures we reviewed also provided evidence that such projects can contribute to unused capacity for a service in the community. The following examples illustrate such situations.

- In the southern Los Angeles area, a hospital entered into a joint venture mammography clinic, in part to provide a more pleasing and self-contained setting for outpatients seeking only mammography services. The hospital also retained its in-house mammography facility. High-volume mammography clinics generally perform 30 to 40 procedures per day. In 1993, the joint venture averaged about 10 procedures per day, while the in-house facility averaged about 8, according to a hospital administrator.
- In northern Los Angeles, a hospital entered into an MRI joint venture located across the street and established its own MRI facility, in part to meet the expected demand for MRI services. The establishment of more MRI facilities than anticipated in the area resulted in demand for services at the two facilities that did not meet projections. The hospital MRI, which performs about 1,200 scans per year, could absorb the entire workload of the joint venture, according to a hospital administrator.
- Of the 10 joint ventures we visited that offered MRI services in 1991, 6 centers operated substantially below their capacity.[7] Hospital and joint venture administrators attributed the hospitals' low utilization to increased competition, and excess capacity, in their communities for MRI services.

This excess capacity can have negative consequences on the health care system. The cost of building and maintaining excess capacity is ultimately added to the cost of providing medical care in the community. Further, a joint venture's potential unprofitability as a result of excess capacity

[6]Letter to editor from Beverly C. Morgan, M.D., New England Journal of Medicine (Mar. 25, 1993), pp. 884-885.

[7]These 6 MRI centers all performed fewer than 4,000 scans in 1991; 3 centers performed fewer than 2,500. In a prior GAO report, Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992), we found MRI utilization was typically over 4,000 scans per year. In Michigan, which requires state approval for new MRI installations, regulators require a minimum projected workload of 4,500 scans per year.

would appear to create greater incentive for physician-owners to increase self-referrals.

Regulatory Scrutiny Has Reduced the Number of Joint Ventures

Increased scrutiny by federal regulators is the main reason for the recent decline in joint ventures, according to hospital administrators and health care attorneys we interviewed. They said that recent legislation and stronger enforcement action by the IRS and HHS have prompted many hospitals to reevaluate existing ventures and exercise great caution in considering new ventures. This was borne out in our survey of 95 nonprofit hospitals. Forty-nine of these hospitals had participated in joint ventures and of the 49, 17 (35 percent) reported to us that they had restructured or dissolved their ventures in response to increasing regulatory pressures. Because of similar concerns, 26 percent of the nonprofit hospitals responding to the 1991 AHA survey reported having modified or terminated their joint ventures sometime before December 1991.

We identified three principal federal actions, and a variety of state actions, that deter joint ventures between nonprofit hospitals and physicians. The federal efforts include legislation, an IRS opinion, and HHS enforcement efforts.

Omnibus Budget Reconciliation Act Provisions

In reaction to reported problems with excessive clinical laboratory tests, the Congress adopted a provision—commonly known as the Stark Amendment—in the Omnibus Budget Reconciliation Act of 1989. This legislation responds to concerns raised in GAO and HHS/IG studies conducted in the late 1980s, which found that physicians ordered more, and more costly, laboratory services when they had an ownership interest in the laboratory. The Stark Amendment, which took effect January 1, 1992, prohibits Medicare payment for laboratory services, with certain exceptions, if the tests are ordered by a physician with an ownership interest in the laboratory.

Passage of this provision appears to have had a substantial effect on the number of clinical laboratory joint ventures with nonprofit hospitals. AHA's hospital surveys found that the number of such ventures had already dropped from 70 in 1989 to 52 in 1991, the last year for which national data were available. Hospital administrators told us that they, and others they know of, continue to dissolve or restructure their laboratory joint ventures. Our survey of 95 nonprofit hospitals found no ongoing clinical

laboratory joint ventures. Five of the surveyed hospitals had such ventures in the past, but all five restructured or dissolved them specifically in response to the Medicare payment ban provisions in the Omnibus Budget Reconciliation Act of 1989.

IRS Opinion on the Sale of Future Revenues

One form of joint venture consists of a hospital's selling the rights to the future revenues generated by an existing hospital department, such as outpatient surgery or radiology, to the venture in return for partial ownership in the venture. In 1991, the IRS determined—in General Counsel Memorandum 39862—that such ventures jeopardize the hospitals' tax-exempt status in three ways. First, such ventures allow a hospital's net earnings to accrue to private individuals or shareholders. IRS regulations prohibit any part of a tax-exempt hospital's net earnings from going to these groups. Second, the private benefit stemming from these ventures is more than incidental to the public benefit achieved. IRS requires that a tax-exempt hospital must serve public, rather than private, interests. Finally, such ventures may also violate federal anti-kickback laws.

Few, if any, joint ventures involving the sale of future revenues continue to operate, according to the Director of IRS's Exempt Organizations Technical Division. Following publication of its decision, IRS provided a limited period of time, until September 1, 1992, in which hospitals could terminate such ventures without loss of their tax-exempt status. As of May 1993, the Director told us 21 ventures had approached IRS; all 21 were in the process of dissolving or restructuring their joint ventures. None of the hospitals we visited participated in such ventures. Some hospital administrators told us that they had considered similar ventures in the past but decided against participating because of concerns about jeopardizing their tax exemption.

Medicare Anti-Kickback Statute

The HHS/IG, along with the Department of Justice, enforce the Medicare Anti-Kickback Statute. The statute makes it a felony to give or receive any remuneration (anything of value) as an inducement for referrals under the Medicare or Medicaid programs. To clarify this broad language, in 1991 HHS issued "Safe Harbor" regulations, which describe practices that would not be subject to sanctions. Also, in 1989 and 1992, the IG issued special fraud bulletins that highlighted arrangements that would be subject to increased scrutiny.

The IG's first sanction (initiated in 1989) of a joint venture as a violation of the Medicare Anti-Kickback Statute is currently being challenged in court.

The case was decided in the IG's favor in district court in February 1993 but was subsequently appealed. Although several hospitals in our survey had restructured or dissolved their joint ventures in response to greater IG scrutiny, other hospitals were awaiting the appeal results before taking any action.

State Limits on Referrals by Physician-Owners

Several state legislatures have passed laws limiting physician ownership and patient referrals. Current restrictions range from mandatory ownership disclosure in some states to extensive prohibitions on physician self-referrals in several others. Thirteen states have enacted significant limits on physician self-referrals, according to the HHS/IG General Counsel. Many more states are considering similar legislation. As of May 1993, bills limiting physician self-referrals had been introduced in the 1993 legislative sessions in 27 states.

In two states that recently enacted broad restrictions on physician self-referral, we found indications that joint ventures were being immediately affected. When fully implemented, new legislation in Florida and Illinois will, in effect, ban most joint ventures in those states. Each state provides a phase-in period of up to 4 years; however, some hospital administrators and health care attorneys told us they are restructuring and dissolving their joint ventures in anticipation of the self-referral ban.

Agency Comments

Although we did not obtain written comments on this report, we provided copies of our draft report to IRS, the HHS/IG, and HCFA for their review. Agency officials generally agreed with our report, and we incorporated their technical comments where appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days after its issue date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Commissioner of the Internal Revenue Service, and interested congressional committees. Copies will also be made available to others upon request.

If you or your staff have any questions about this report, please call me on (202) 512-7118. Other major contributors are listed in appendix I.

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